



# MEP NEWS

"Montgomery Emergency Physicians is the recognized leader in providing exceptional emergency medical care. We improve the health and promote the well being of the individuals and organizations we serve."

Volume 4, Issue 1

April 2004

## MEP LEADERSHIP

### MEP President

David G. Srour, MD

### Emergency Department Chair

Angelo L. Falcone, MD

### Marketing Director

Julia LaJoie, MD

### Director Pediatric Medicine

Scott Freedman, MD

### Staff Development

David N. Klein, MD

### Quality Improvement

Brett A. Gamma, MD

### Web Services

Thai McGreivy, MD

### Director of Mid-level Providers

Mark Kline, PA-C

### Interim Director of Mid-level Providers

Michelle LeBoroy, CRNP

## Inside this issue:

Low Hanging Fruit	2
The Bigger Picture	3
Web QI	4
Monthly ED Review & PI	5
A Patriot of Our Own	6
Finding our Brown Ferns	8

## Chairman's Update: Debts to Pay...

All of us have our obligations in life to family, teachers, mortgage companies, lending institutions and ourselves. What debt do we owe to our patients?

We are expected to provide exceptional quality of medical care, delivered efficiently, cost effectively, and with attention to the patient's comfort and satisfaction. I believe there is another expectation; namely, that we will continually learn from every encounter and more importantly, disseminate that knowledge to other practitioners. The end result being a higher level of care.

On an individual basis this is experience learning. I learned how to do this because I've done it hundreds of times. On a national level, this is dissemination of standards of care and JCAHO updates. We have a great opportunity (and obligation) to develop a process at our local system level to teach one another how

to provide better care.

At our strategic planning sessions, we spoke on disseminating the experiential knowledge of MEP, commonly called knowledge management in business systems. While other organizations do this in some form or fashion with case reports, M & M, clinical pathways, I believe something is missing. That something is you!

Passive reception of information through reading or classroom lectures has been demonstrated to be a poor way to retain information. Much more is learned when you have to teach something to someone else. This may be a new central line technique to a colleague, a soccer kick to your child, or the intricacies of sepsis management to the nursing staff. Intuitively, we all know this as many of us still remember the lessons we were required to teach in residency or training.

Happy Spring!



How do we do this when all of us are too busy with all the other obligations of life? First, use the "KISS" methodology. Second, recognize and encourage each other that this is a great thing. Third, demonstrate to others outside our organization, yet another reason why MEP is a great place to be because of this process. Probably the most important reason is because it will make you a better clinician. I believe it is a debt we owe to ourselves, our patients and the organizations we serve. There is a Jewish proverb that you lead your life with the intent to make the world a little better everyday. Words to live by I would suggest.

-Angelo Falcone, MD



## Low Hanging Fruit

### David Srou, MD: Vice Chairman Emergency Services



As the name of this column suggests, this ongoing column will feature tips, pearls, words of wisdom,

and simple ideas that are easy to implement, cost little, and have low resistance from staff. Common myths and urban legends will also be dispelled. These tips can have a substantial impact on efficiency, resource utilization and patient outcome.

Everyone is encouraged to submit ideas for publication. A prize will be given at end of year for best idea!

Coagulation studies– Quite often a PT and PTT are obtained for patients on Warfarin. These are separate tests

with separate charges. The PTT is not useful to determine therapeutic targets.

Subcutaneous epinephrine for allergic reactions- Epi has been given for years subcutaneous. Recent studies have shown that Epi is erratically absorbed by this route and the recommendation is to give IM.

MD Consult– Online resources for physician consult are available to all staff at SGAH. A password and login can be obtained from the medical library. In addition to the online textbooks and articles, the patient instructions are a great resource for gaps in EMSTAT or for more obscure diagnoses. There are over 3000 in English and Spanish. It may be helpful to print information at the beginning of an encounter and give to pa-

tient and family to read while they are waiting. This reduces questions and answer period and is a nice satisfier.

Heme testing NG aspirates– The card says not to be used for gastric secretions *and for good reason*, it is overly sensitive and results in many false positives. When you think about it we're really only concerned with gross appearance, negative, gross blood or coffee grounds and clearance with irrigation.

Post it arrows on order sheet– A great help to Unit Secretaries, Techs and Nurses to draw attention to a new order or multiple orders. You can write specific instructions on the arrow, e.g. add to blood in lab, etc. Post It arrows are available in the nursing station.

## Benisource Flex Benefits Additional Reimbursements

### Susan Boch, Practice Administrator

For those employees of MEP that participate in the Flex Spending Plans, the healthcare expense plan in particular, there has been a favorable change in the items that are reimbursable. The IRS, the agency that regulates pre-tax spending plans, allows the cost of over-the-counter (OTC) drugs used for "medical care" to be reimbursed under the MEP plan. With allergy season upon us, spring colds and poison ivy waiting in the wings, this will be useful information.

The IRS states that OTC drugs or medicines merely beneficial for general health are NOT eligible for reimbursement because they are not considered "medical care". Medical care expenses must be incurred for the "diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affect-

ing any structure or function of the body." Here are some examples:

Ineligible for reimbursement:

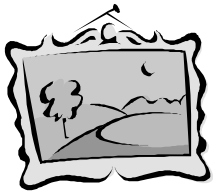
Breath mints, Cosmetics, Deodorants, Dietary supplements, Face Creams, Feminine Hygiene Products, Fiber supplements, Hair removal treatments, Hand or body lotions, Lip balms, Mouthwash, Sleep aids, Soap, Sunscreen, Toothpaste, Vitamins (one a day)

Eligible for reimbursement: Aspirin, Allergy medicines, Antacids, Anti-fungal medicines, Anti-itch lotions and creams, Bandages, Cancer/cold sore medicines, Chest rubs, Cold medicines, Cough suppressants, Diaper rash ointments, Decongestants, Motion sickness medication, Nasal sprays, Pain relievers, Smoking cessation drugs (patches,

gum)

If you have additional questions, do not hesitate to contact the BeniSource Flexible Benefit Plan Administrator. Telephone: 301-595-0800. Toll-free: 1-800-344-2954. Fax: 1-800-981-1119. Susan Damron, Benefits Coordinator at PSR/Medical Edge can be reached at 1-800-346-0747, ext. 3709. BeniSource reimbursement forms can be found at: [www.benisource.com](http://www.benisource.com). Click on participant and you will have the option to access reimbursement forms on-line.





## The Bigger Picture : Ife Omitowoju, MD - Pediatric Services

As I settled into my car after my shift as a hospitalist on the pediatric ward, I wondered once again why I decided to pursue a career in this profession. My thoughts went back to my medical school interviews and my answers about how I wanted to “help people and make a difference in health-care”.

I’m sure that we have all had days like that when despite how much you try to help your patients and their parents, nothing seems to be enough. It seems that nothing you did was right despite the fact that the child is better and being discharged. We have all had days when parents are angry at the situation and take it out on you. We have all had days when parents mention the word “attorney” just to see if you will come see them any sooner. It is after days like this that my mind wanders back to the months I spent in Nigeria working in a clinic during medical school. Granted, I was only a student and my work was supervised by attendings but never more have I felt so needed, so appreciated as a health care provider.

I was born in Ibadan, Nigeria and lived there until my teenage years. It was during those years that my desire to become a doctor was formed. As a child, I watched the heroic efforts of physicians that saved the lives of my brother and sister when they were afflicted with serious illnesses. I knew that I wanted to do the same as an adult. My brother and sister both had gastroenteritis and had they had earlier access to medical care and IVF hydration they would not have be-

come severely dehydrated. We treat acute gastroenteritis everyday here and our patients hardly ever become critically ill because oral rehydration and IVF hydration is easily rendered.

I completed my high school, college, and medical training in the United States. As mentioned before, I spent two summers working in a clinic in urban Nigeria. It was there that my physical examination skills were honed. There is a lack of equipment and lab services available to aid in diagnosing patients. This forces the clinician to rely fully on his/her physical diagnostic skills. The contrast and disparity between healthcare throughout the world became very clear to me those months. For example, we probably have about at least 5 MRI machines within a 25-mile radius in this area whereas; there was not one MRI machine available in the Western Hemisphere of Africa when I was there. In most developing countries, there is no such thing as health insurance and healthcare is only available to those who can afford it. For example, a surgical procedure is only available to those who are able to pay in advance. The patient pays for everything from the IV tubing to the gloves the physician will use during the surgery. In addition, there is always the worry of a power failure during the surgery; and all concerned parties hope that the back-up generator will work if needed. In most situations, except in the large university hospitals, lab services are not available on-site and the patients need to wait for days before results are available. Most illnesses are treated based on symptoms.

Don’t get me wrong, most of these countries have better resources and equipment however, they are only available at a high cost to the few who can afford them. Specialists are few and far between and almost always only accessible to the rich and influential.

Despite our limitations, patients were always appreciative and grateful for the attention and the health care given, they knew not to take good healthcare resources or healthcare delivery for granted. I learned in those few months to appreciate the amazing resources we have here in the United States. We all know that there are many problems with this system but we never have to worry about having the basic equipment and materials needed to treat our patients. We also know that as patients, we have the most current medications and treatment options at our disposal.

As I sat in my car, my mind drifted back to the present, and suddenly the frustrations of the day did not seem so bad. For the most part, I have the resources I need to be able to diagnose and treat my patients. For the most part, my patients also have the resources available to them to be able to seek and comply with treatment options. Even though we have all had frustrating days like this, we know that most patients are grateful and appreciate the care given. In this day and age when it seems everything is wrong with the healthcare system, we should also take time to reflect upon our abundance and appreciate the opportunity to practice within this.

***No matter how long the winter, Spring is sure to follow... -Guinean Proverb***



## Web QI Thai McGreivy, MD

I again wanted to use this forum to thank all of you for your continuing efforts with peer review.

The positive results we have seen just keep coming! The bounce backs have been down for six consecutive months since we started the WebQI/peer review process for all MD's. This is quite an achievement. Keep in mind, we have never seen more than two con-

secutive months since we started tracking bounce-back data prior to implementing WebQI.

We hope to see a corresponding decrease in level III and IV's from the ED Review Committee. Thankfully we have few of these scores, so it may be difficult to see an impact through this marker. We have witnessed our own healthcare effect where we

see improvement simply from the fact that we know we are actively and randomly reviewing charts.

As a final reward, charts are showing up in your mailbox less frequently since we moved to an every other month format.

I will keep you informed and again please keep up your hard work.

*To live long, live slowly. -Cicero*

## Medical Mutual Risk Management Seminars Susan Boch, Practice Administrator

As you are aware, MEP changed their malpractice carrier to Medical Mutual from Princeton effective December 1, 2003 due to Princeton leaving the marketplace. Before Princeton withdrew from Maryland as a medical malpractice insurer, the rates for EM coverage in 2003 had skyrocketed relative to previous years. Medical Mutual is the highest rated professional liability insurer in the state and MEP wants the best coverage available for their providers. Anything but Medical Mutual could not be considered. In testimony to the growing malpractice crisis in our country, MEP incurred an additional significant premium increase with the move to Medical Mutual.

Medical Mutual offers risk management courses throughout the year for which MEP will receive a 5% reduction in premium the following calendar year. MEP is requiring each of its insured

providers to attend a course before year's end. This applies to all physicians, physician assistants and nurse practitioners. There is a large selection of courses and dates from which to choose a topic that interests you. The cost is \$50.00 and provides the attendee with CME credit. The courses are held in the evening and last approximately three hours. A light meal is provided.

Each provider received the information in his or her mailboxes during the month of March. If you need another, contact Sue Boch at 240-364-2516 or [sboch@med-edge.com](mailto:sboch@med-edge.com). You may also access the same materials online at [www.weinsuredocs.com](http://www.weinsuredocs.com). Click on **Physicians, State of Maryland Only** (on the left hand side of the page), then click on **Risk Management** (also on the left hand side of the page) then click on **Physician Seminars** located on the right hand side of

the page. Here, you are able to learn about each seminar, the CME offered per course, register on-line and obtain driving directions to the class.

The cost of professional liability coverage will only increase as the years progress without intervention such as was lobbied for during this most recent legislative session. MEP is requiring that each of our providers accept this challenge to reduce the cost of professional liability coverage. In addition to reducing costs, the Medical Mutual courses offer insightful information that is helpful to your practice. Attendance has a three-fold benefit: premium reduction, professional enrichment, and CME credit. Make your reservations today.



# Monthly ED Review Committee and PI Committee Letter: Brett A. Gamma, MD

Hello to all. I would like to take this opportunity to inform everyone about a process which I recently went through with other members of the hospital, and how it will affect all of us. It involves tuberculosis, which continues to be a threat throughout the world. Did you know that Montgomery County has the second highest TB case rate in Maryland? Shady Grove is considered a medium risk level per OSHA criteria based on the number of cases and PPD skin test conversions. A TB committee was formed for several reasons. First, to recognize early patients who are known or suspected of having TB. Second, appropriately isolate patients to negative directional airflow rooms to reduce the risk to others. TB cases may enter the hospital through a number of avenues including but not limited to the ED, direct admission process, and outpatient surgery. Finally, institute effective treatment early.

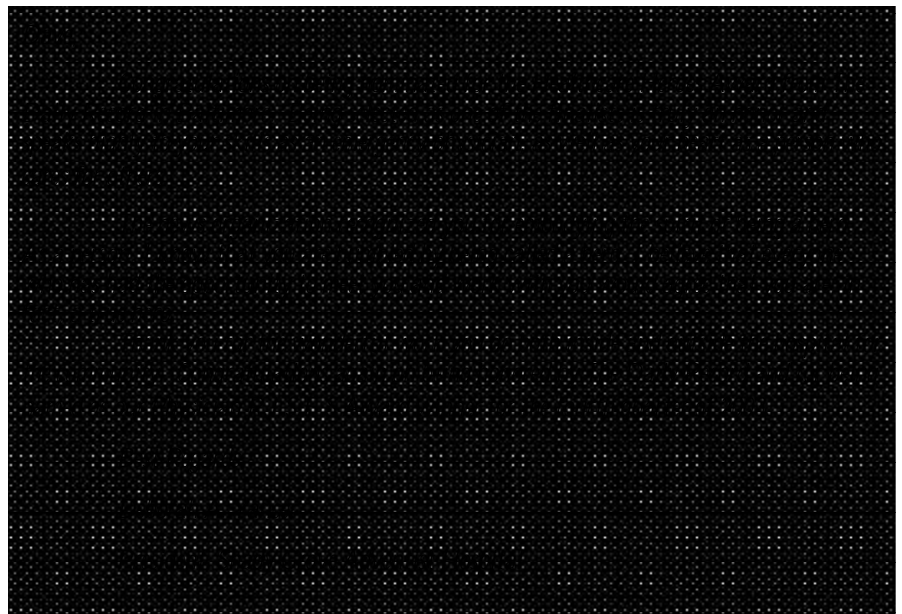
With regard to the ED, several changes have been implemented. Masks are provided to patients as they enter the emergency department to reduce any possible exposure to others. TB screening has been developed as part of nursing competency and a screening form has been developed and is kept at the triage station. T-sheets pertinent to respiratory complaints have been modified to incorporate several risk factors for TB. Under ROS, history of or exposure to TB, hemoptysis and weight loss have been added to the Cough/Fever, Dyspnea and Wheezing/Asthma T-sheets to encourage us all to think about TB. According to the Harbor-UCLA Triage Criteria for Respiratory Isolation Tuberculosis Precautions (RIPT), The four symptoms/complaints are cough (any duration), fever/chills/night sweats, weight loss > 10 pounds and hemoptysis. Other risk factors include patients who are

HIV, foreign born, homeless or in a shelter and those who have been in jail within the last two years. RIPT was developed to help screen for patients who need respiratory isolation and is also useful for risk stratification. If you think TB, please place in a negative flow room (Rooms 1 and 2). If already used, place in room 13 or at least ensure a mask is on the patient. Chest x-ray findings are variable and not always the classic upper lobe infiltrate or cavitory lesion.

Standing orders for the ED have been developed, however, it is currently unclear as to whether or not they will be used. I will keep you updated on this. The hope is that with these changes in place, we will be able to lower our PPD conversions within the hospital. So if you are even thinking about TB, please isolate.

## The R.I.S.E.S Award

recognizes top physicians who live and work in a manner that reflects the five values of our hospital: Respect, Integrity, Service, Excellence and Stewardship (RISES). Shady Grove Adventist Hospital is pleased to announce that David Srour, MD is the fourth quarter of 2003 award winner. Congratulations Dave!





## A Patriot of Our Own...

On Wednesday, April 21, 2004, in a ceremony attended by Ms. Debbie Yancer, President, Shady Grove Adventist Hospital and Michael Franklin, Vice President and Chief Operating Officer, Shady Grove Adventist Hospital, Montgomery Emergency Physicians became the proud recipient of the Patriot Award. This prestigious award conferred by the United States Department of Defense and the National Committee for Employer Support of the Guard and Reserve recognizes MEP as an employer who supports an employee's commitment to country through service in the National Guard and Reserves.

First Lieutenant Mark Kline, Physician Assistant, and long time employee of MEP, was deployed to the Middle East in July 2003. MEP has demonstrated their support of Lt. Kline's mission by supporting his rapid induction into active military service, continuing company benefits while deployed and keeping in contact with him and his family over the past year.

MEP in turn, wishes to thank Mark for his service to country and contributing to the national security. Mark's thoughtfulness during his deployment to consider MEP for recognition is above and beyond his other competing interests; safety, our collective security and the pressures of separation from family,

friends and home.

The National Committee for Employer Support of the Guard and Reserve (ESGR) was established, by Presidential proclamation, as an operational committee under the Office of the Secretary of Defense. It is the sole Department of Defense agency directed to promote public and private understanding of the National Guard and Reserve in order to gain employer and community support that encourages employee and citizen participation in the National Guard and Reserve. Today, ESGR is comprised of a community-based volunteer network of over 4,500 members, who serve on 54 committees (in every state, the District of Columbia, Guam, Puerto Rico and the Virgin Islands), implementing employer support programs within their local communities.

Since the collapse of the Berlin Wall and the downfall of Communism in 1989, the active duty military has been reduced nearly 40 percent, and the Reserve forces have been reduced nearly 25 percent in expectation of a "peace dividend." The decision to make this reduction in military forces did not anticipate that the U.S. would, in fact, maintain its Cold War level of global military involvement. In order to continue this operations tempo (OPTEMPO), the military has had to increase its reliance upon the

Reserve forces. Today, in both manpower and force capability, the Reserve Components comprise nearly half of the Total Force, excluding retirees.

As a result, employers are being asked to sustain a much greater level of employee absence and related consequences. The complications this "contract" create for employers are compounded by low unemployment rates, an anticipated reduction in the national workforce of nearly 15 percent over to next 10-15 years, and a growing reliance by both military and civilian employers on small segments of the workforce with specific job skills that are in high demand. The current National Defense Strategy indicates that the National Guard and Reserve, while decreasing in size, will be full partners in the fully integrated Total Force. Reserve Forces will spend more time away from the workplace defending the nation, supporting a demanding operations tempo and training to maintain their mission readiness.



**SAVE THE  
DATE**

MEP Family Picnic, Sunday,  
August 1st, 2004

**KEEP YOUR EYES**

**OPEN FOR FURTHER  
DETAILS!**

*Congratulations!*

**Montgomery Emergency Physicians are pleased and proud to announce that David Srou, MD, has successfully completed the Undersea and Hyperbaric Medicine subspecialty certification examination from the American Board of Emergency Medicine.  
Congratulations to Dave!**

## MEP-OLAP on the PSR Website Sue Boch, Practice Administrator



If you are interested in tracking your productivity, you may wish to re-familiarize yourself with the PSR/MEP website. With the introduction of the On-Line Analytical Processing (OLAP) reporting software program, you are able to interactively view your personal productivity history and view peer comparisons for the following metrics: RVUs per hour, RVUs per pt and patients per hour instead of viewing static graphs that require manual updating.

To access the website, go to [www.psrinc.net](http://www.psrinc.net). Click on "Home" on the left hand side of the page. The click on "Client log-in" located at the bottom of the right hand column. This will bring you to the login screen. Your login and password are identical: the first initial of your first name and you last name, no spaces. (dsrour/dsrour) This will then bring you to a screen with multiple icons. The bar graph on the upper left hand side of the screen is the portal to your productivity data.

Once you click on the bar graph, you are brought to a screen that says PSR Power Tools. Click on the icon to enlarge the view to the entire screen (maximize size). Just above the bar graph are gray boxes, each with an arrow on the left margin of the box. This is the interactive portion of the OLAP tool. The year-month bar allows you to look at a particular month as a peer comparison. The POSITION drop down menu allows you to look at Main ED physicians, Peds ED physicians, MLPs etc. The CAMPUS menu has Shady Grove as its singular option. The DOS box allows you to look at a particular year, quarter or month.

Below the graph, you will see a table with the values for RVUs per pt, RVUs per hour and PPH by provider. A number that was assigned by PSR when you became associated with MEP identifies each provider. This number is unique to you. If you do not know your Pint Number (a PSR moniker), contact Sue Boch at [sboch@med-edge.com](mailto:sboch@med-edge.com) and it will be emailed to you. You can click on your pint number to highlight the cell and then click on history to view your trends for these same metrics over

several months.

In addition to viewing your productivity metrics, you may use the OLAP system to view your patient satisfaction results. Returning to the same screen where you selected productivity data for viewing, you may select patient satisfaction instead. Because pt satisfaction is the newest addition to OLAP reporting, there is also an icon to view or download the OLAP instructions. The process is very similar to OLAP for productivity.

Patient satisfaction scores and monthly productivity data are being updated concurrent with data acquisition: as the surveyor speaks to a patient and records the responses to the questions, they are being incorporated into the OLAP system. Productivity data is updated by the 20<sup>th</sup> of the month for the previous months clinical hours, concurrent with productivity compensation calculations.

If you need assistance using this tool, please contact PSR in the Dallas office. The primary support number for this tool is 972-739-3707 or 1-800-346-0747, ext 3707. You may also email Justin Schaper: [jschaper@med-edge.com](mailto:jschaper@med-edge.com).



*Clare Ellen Gamma, 8 pounds and 10 ounces and 21 inches long, was born on Friday, March 19, 2004 to Dr. Brett Gamma and wife Mary Kay.*

*"Clare is as beautiful as her mother..."*

*Congratulations Gamma Family!*



**Who is that masked man?**



# Finding our Brown Ferns

## Michael Cetta, MD

As MEP grows we are continually trying to improve ourselves. We have hired a quality staff of physicians and mid-level practitioners, instituted a comprehensive QI process, on-line chart review, and detailed coaching sessions. There is little doubt that MEP is destined for greatness. However, in our effort to succeed we need to not only focus on what we are doing, but also focus on what we are NOT doing – we need to find our “brown ferns.” Bear with me while I explain...

Imagine you work in an office with a nice desk, window view, and a fern growing in the corner. You forget about the fern, and over time it dies and turns brown. You do not notice the dead plant because you see it everyday and have become accustomed to it. You simply forget about the brown fern, but people who visit your office notice it right away. Despite your flawless work, your customers are struck by the neglect you have shown for the fern in the corner. Like most work environments, we have many “brown ferns” in our Emergency Department, some may be obvious, and others are not. We must set out to find our “brown ferns” and turn them green again.

The first challenge is to find the problems. We need to look at our department from the perspective of the patient. How do things look, smell or sound to a first time visitor? Perhaps we need to ask patients what their thoughts are about the Emergency Department environment. How well does our department fulfill that need? Do the dirty walls or dusty clerical station across from room 9 offend patients? Do the bloodstains left on the bed sheet after a blood draw disgust people? Do the sounds of laughter offend patients? Perhaps our casual dress attire conveys the wrong message. There are certainly hundreds of “brown ferns” in our department. It is our goal to find them.

The second challenge is to solve the problem. Fixing some of the obvious issues can be simple – such as painting the walls and organizing a work area. But other issues reflect a need to change our culture. If we determine that our dress code is too casual or that laughter is conveying a bad message, than “the fix” involves the entire staff – physicians, MLP’s, nurses, techs, registration, etc. Everybody has to agree and buy into the need to improve our im-

age. Solving this second challenge will require adoption by the entire staff.

The final challenge will be to make our changes stick – avoid growing or re-growing our “brown ferns.” Once we have made progress and shown an obvious improvement, it will be imperative that the staff perpetuates the model. The commitment to change and improvement needs to come from the top. Charge nurses, physicians, and MLP’s, will need to encourage staff to stay focused on the changes. This will be the most difficult challenge to overcome.

Perhaps this “brown fern” concept is new, but the principle, we can all agree, is sound. Let us try to look around at where we work, what we do and what we say. Pay attention to the small stuff. Identify our “brown ferns” and if we find the ones that matter and correct them, we can become the truly elite department we want to be.

Over the next few weeks we will be gathering ideas from all of the staff. You will see suggestion boxes in the ED and contact via each of the staff meetings. If you have any ideas, please email me directly at [Mcetta@mac.com](mailto:Mcetta@mac.com).



### MONTGOMERY EMERGENCY PHYSICIANS

SHADY GROVE ADVENTIST HOSPITAL  
9901 Medical Center Drive  
Rockville, Maryland 20850  
Phone: 301-279-6550  
Fax: 301-217-5107

*“Best care  
anywhere”*

**Newsletter Design provided by: Ruderman Design**

**301-371-6686 or [lbaxter@adelphia.net](mailto:lbaxter@adelphia.net)**

